
PROPOSED REGULATIONS

Proposed changes are shown in red-line (tracked changes).

Chapter 1.00.

References and Annotations

REGULATORY AUTHORITY

805 CMR 1.00: ~~M~~G.L. c. 32A, § 2.

CMR T. 805, Ch. 1.00, Refs & Annos, MA ADC T. 805, Ch. 1.00, Refs & Annos

Current through April 13, 2012, Register #1206

§ 1.01 Authority

805 CMR 1.00 through 9.00 is promulgated in accordance with the authority granted to the Group insurance Commission by ~~M~~G.L. c. 32A and c. 32B, § 19.

(1) Administrative Bulletins. The Group Insurance Commission may issue administrative informational bulletins that provide the following:

(a) set out policies that are consistent with the substantive provisions of the Commission's regulations;

(b) specify the information and documentation necessary to implement the regulations;

(c) provide interpretations of the regulations; and

(d) to assist persons subject to the regulations to meet their obligations.

(2) Severability. The provisions of 805 CMR 1.00 through 9.00 are severable. If any provision or the application of any provision is held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 805 CMR 1.00 et seq. or the application of such provisions.

§ 1.02 Definitions

As used in 805 CMR 1.00 through 9.00, the terms below have the following meanings:

Additional (Optional) Life Insurance. Commission-sponsored Term Life and Accidental Death and Dismemberment Insurance, based upon ~~ana State~~ Employee's annual compensation and age, for which State Employees and State Retirees pay the full premium cost and which is in addition to the Basic Life Insurance.

Annual Enrollment. The period in which eligible insured and uninsured ~~employees, retirees or survivors~~persons may enroll themselves and their Dependents in the Commission's benefit programs or make changes to their status or benefits in those programs that become effective on July 1st.

Basic Life Insurance. Commission-sponsored Term Life and Accidental Death and Dismemberment Insurance, for which eligible Employees and Retirees pay a portion of the premium cost and the Commonwealth pays the premium balance.

Calendar Month. For the purpose of premium payments and Commission coverage, a full month, e.g., March 1st through March 31st.

Child. 1) A son or daughter by birth or legal adoption (including any probationary period); 2) a minor placed in an adult's custody pursuant to an order from a court of competent jurisdiction, including a guardianship order; or 3) a person who is dependent upon another person for support and who lives in that other person's household, where there is evidence of a parent-child relationship satisfactory to the Commission, up to age 26 or two years after the child ceases to be an IRS dependent, whichever occurs first.

COBRA. Consolidated Omnibus Budget Reconciliation Act.

Commission. The Commonwealth of Massachusetts Group Insurance Commission.

Contributory Insurance. Insurance for which Employees and Retirees pay part of the premium and the Employer or the Commonwealth pays the premium balance.

Continuation Coverage. Federal and state non-group coverage, including COBRA and conversion coverage, available to ~~insured~~those who were formerly Insureds but whose eligibility for group insurance coverage through the Commission has ended.

Deferred Retirees. Former Employees ~~or Municipal Insureds~~ whose employment ~~terminates~~has terminated and who have vested rights to a retirement allowance, currently deferred, relating to their employment. Persons receiving a pension or retirement allowance whose monies are withdrawn or transferred to a non-participating retirement system are not Deferred Retirees. Otherwise qualified Former Municipal Employees may only be Deferred Retirees for as long as their Municipal Employer continues to offer insurance to Municipal Insureds through the Commission.

Dental and Vision Benefits. Dental benefits for certain preventive and other non-preventive dental care, and vision benefits for certain preventive vision care, products and services, available to ~~Employees who are not covered by collective bargaining or do not have other dental coverage, including managers, legislators, legislative staff, and certain Executive Office staff (but excluding employees of authorities, higher education or the trial court system).~~ eligible Insureds pursuant to § 9.22.

~~Dependents.~~

~~(a) Spouses of insured Employees, Municipal Insureds or Retirees and their children by birth or legal adoption (including any probationary period);~~

Dependent.

(a) A Spouse of an insured Employee or Retiree;

(b) A Former ~~spouses~~Spouse of an insured ~~Employees, Municipal Insureds~~Employee or RetireesRetiree entitled to coverage pursuant to M.G.L. c. 32A, § 11A and their children by birth or legal adoption (including any probationary period);

~~(or G.L. c.) Children of insured Employees, Municipal Insureds or Retirees placed in their custody pursuant to an order from a court of competent jurisdiction, including a guardianship order; 32B, § 9B;~~

(c) Up to age 19, or two years after ceasing to be an IRS dependent, but only to age 26, the Child of:

1. an insured Employee or insured Retiree;

2. an Employee's or Retiree's insured Spouse or insured Surviving Spouse; or

3. an Employee or Retiree's insured Former Spouse, to the extent the Child was born prior to the date the divorce became final.

(d) ~~Children~~Up to age 26, the IRS dependent of an insured Employee, Retiree, or Surviving Spouse;

(e) Up to age 26, a person who ~~are~~was previously an IRS dependent of an insured Employee, Retiree, or Surviving Spouse, for two years after ceasing to be an IRS dependent;

(f) The Child of a person who is eligible as a Dependent under paragraph (c), (d), or (e), above;

(g) A Child who is dependent upon an insured Employee, ~~Municipal Insured or~~ Retiree, or Surviving Spouse for support and who ~~live in their~~lives in the Employee, Retiree, or Survivor's household, where there is evidence of a parent-child relationship satisfactory to the Commission, up to age 26 or two years after the child ceases to be an IRS dependent, whichever occurs first;

~~(e)-(h) A Student who is the Child of an insured Employee or Retiree, or of an insured Employee's or Retiree's Spouse, Surviving Spouse or Former Spouse, and that Student's Children, if any;~~

~~(i) A Handicapped Children and Students as they are~~Dependent as defined in ~~805-CMR-1.02: Dependents~~this section;

~~(f)-Children~~j) A Child of:

~~1. an insured Employee's or Municipal Insured's or Retiree's~~Employee, Retiree, Spouse, Former Spouse, or Surviving Spouse or Former Spouse; or

~~2. an insured Employee's or Municipal Insured's or Retiree's Surviving Spouse's child, up to age 26 or two years after ceasing to be an IRS dependent, whichever occurs first.~~

~~(g) Newborn children of an insured Employee's, Municipal Insured's, Retiree's or Surviving Spouse's son or daughter until the earlier of age 26 or two years after ceasing to be an IRS dependent.~~

Elderly Governmental Retirees. Employees who retired from the Commonwealth or one of its political subdivisions before January 1, 1956, and who are eligible for separate insurance coverage under the provisions of ~~M.~~G.L. c. 32A, § 10B.

Emergency Employment. Employment for an unforeseen Employer emergency, limited to a specified time period, usually not more than 30 days.

Employee. ~~Persons~~Person whose time is devoted to the service of the Commonwealth or one of its political subdivisions that is authorized to participate in Commission benefit programs by express reference in state law, who ~~work~~works during the Regular Work Week of permanent employees and who ~~contribute~~contributes to a State pension system ~~or, a Housing, Redevelopment or Optional Retirement Plan; and persons, or another public sector retirement system; or a person~~ elected by popular vote to state or local government office during the term that ~~they hold~~he or she holds office. State and municipal board, commission or authority members who do not work a Regular Work Week and its requisite statutory hours are not Employees unless expressly otherwise authorized by law. Contributions to an OBRA Plan do not constitute contributions to a public retirement system.

Employer. The Commonwealth or one of its political subdivisions that participates in certain Commission benefit programs by express statutory mandate.

Family Health Coverage. Commission health coverage that includes a person entitled to and enrolled in Commission coverage and his or her eligible dependents.

Former Spouse. A person who ~~is~~was formerly married to an Employee or Retiree and who has been granted a judgment of divorce or of separate support.

124 | **Group Insurance Coordinator.** The person at each reporting location who acts as a liaison
 125 | between the reporting location and the Commission on matters involving the employer's and its
 126 | employees' participation in the Commission's programs.

127 | **Half-time, Half-time Employees.** Active employees who work at least 18.75 hours in a regular
 128 | work week of 37.5 hours, or 20 hours in a regular work week of 40 hours.

129 | **Handicapped Dependent.** A ~~child~~Child of an insured Employee, ~~Municipal Employee, or~~
 130 | Retiree or Surviving Spouse, aged 19 or older, who, ~~upon attaining age 19, is:~~

131 | ~~(a)(a) upon attaining age 19, was~~ mentally or physically disabled and incapable of earning his or
 132 | her own living;

133 | (b) earns an annual income of less than 200% of the Federal Poverty Level; and

134 | (c) ~~upon turning if enrolling after~~ age 26 ~~either returns to Commission coverage within two years,~~
 135 | ~~other than as the Dependent of leaving Commission coverage or provides a new Enrollee,~~
 136 | ~~demonstrates~~ satisfactory proof of involuntary loss of other coverage.

137 | **Health Care Spending Account.** A pre-tax program through which active ~~employees~~State
 138 | Employees who work at least Half Time pay through payroll deduction on a pre-tax basis for
 139 | non-covered health-related expenses.

140 | **Health Coverage, Health Insurance.** Health benefits provided by the Commission to eligible
 141 | Employees and Retirees and their eligible dependents pursuant to ~~M.~~G.L. chs. 32A and 32B.

142 | **Individual Health Coverage.** Health Coverage for a person entitled to and enrolled in a
 143 | Commission health plan.

144 | **Insured.** An Employee, Retiree, ~~Municipal Insured, Surviving Spouse~~Survivor, or Dependent
 145 | eligible for and enrolled in Commission coverage.

146 | **Local Governmental Unit.** A county, city, town or district that participates in the Commission's
 147 | Retired Municipal Teacher program.

148 | **Long-term Disability Insurance.** An income replacement program that qualifies ~~ana~~ State
 149 | Employee to receive a percentage of his or her gross monthly salary, tax-free, after illness or
 150 | injury renders him or her unable to work for more than 90 consecutive days.

151 | **Municipal Employee, Retiree, Survivor, or Dependent.** An Employee, Retiree, Survivor, or
 152 | Dependent whose eligibility for Health Coverage derives from employment or prior employment
 153 | with a Municipal Employer.

154 | **Municipal Employer.** A Massachusetts county, city, town or district that ~~has~~ is an Employer by
 155 | virtue of having formally ~~adopted M.~~agreed or obtained an order to transfer its Employees,

~~Retirees, Survivors, and Dependents to Commission Coverage pursuant to G.L. c. 32B, § 19, or a Commonwealth Charter School, an Education Collaborative, a regional council of government or a regional planning agency that has joined or § 23, including the Commission's Health Coverage or otherwise has met city of Lawrence, to the terms for joining the Commission's coverage as specified in M.~~ extent it is deemed to have accepted ~~G.L. chs. 32A or c. 32B, § 19, per St. 2010, c. 58, § 4(f).~~

Municipal Insured. ~~A Person employed by or retired from a Municipal Employer whom the Commission has determined to be~~ Municipal Employee, Retiree, Survivor, or Dependent eligible for ~~Health Coverage~~ and enrolled in Commission coverage.

Nondiscriminatory Basis. Plans whose coverage does not contain any annual or lifetime dollar or unit of service limitation imposed for care provided by one type of participating provider that is less than any annual or lifetime dollar of unit of service limitation imposed on coverage for the same services by other types of participating providers.

Nurse Practitioner. A Massachusetts licensed registered nurse in good standing who holds authorization in advanced nursing practice as a nurse practitioner under ~~M.~~ G.L. c. 112 § 80B.

~~Premium Due Month. The month in which Insureds' premium is paid for the following month's benefit coverage (e.g., March is the Premium Due Month for Insureds' April benefit coverage).~~

OBRA Plan. A deferred compensation plan that serves as an alternative to Social Security as permitted by the federal Omnibus Budget Reconciliation Act of 1990, (PL101-508, 104 Stat. 1388).

Physician Assistant. A registered Massachusetts physician assistant in good standing who is supervised by a registered physician in accordance with G.L. c. 112, §§ 9C through 9K.

Regular Work Week. An employee's work, in the service of an Employer of no fewer than 18.75 hours, regularly, in a position for which the established work week is 37.5 hours or no fewer than 20 hours, regularly, in a position for which the established work week is 40 hours, or which meets other statutory requirements. Such hours averaged over any period of time do not constitute a Regular Work Week.

~~Retirees. Employees~~ **Retiree.** A person formerly in the service of the Commonwealth or ~~certain one~~ of its political subdivisions that is authorized to participate in Commission benefit programs by express reference in state law, whose services ended on or after January 1, 1956 and who are eligible for and are receiving and continue to receive a retirement or pension allowance from a participating retirement system, including from the Board of Higher Education's Optional Retirement Program, but excluding any OBRA Plan.

Retired Municipal Teachers. Retired teachers of political subdivisions of the Commonwealth that have accepted ~~M.~~ G.L. c. 32B, § 11E, whose applications for coverage are approved by the

191 Commission and who receive a pension from the State Teachers' Retirement Board and who are
192 not eligible for Elderly Governmental Retiree coverage.

193 | **Retirement.** A status that entitles a former Employee to a pension or retirement allowance under
194 any general or special law, either at the time of employment termination or at some future date.

195 | **Seasonal Employment.** Employment in a single position with recurring duties for a short
196 duration, usually for three months or less.

197 | **Separated Spouses.** Spouses who are granted a judgment of separate support or other related
198 legal relief.

199 ~~Spouses. Persons~~**Spouse. Person** joined in marriage, as recognized by state law, to ~~Employees~~an
200 Employee or ~~Retirees-Retiree.~~

201 **State Employee, Retiree, Dependent, or Survivor.** An Employee, Retiree, Dependent, or
202 Survivor who is eligible for benefits pursuant to G.L. c. 32A. Retired Municipal
203 ~~Insureds.~~Teachers and Elderly Governmental Retirees are State Retirees. An Employee, Retiree,
204 Dependent, or Survivor who is eligible for benefits only pursuant to G.L. c. 32B, § 19 or 23, is
205 not a State Employee, Retiree, Dependent, or Survivor.

206 ~~Students. Children under~~**Student.** Child aged 19 years or older but younger than 26 years of age
207 who ~~attend~~attends an accredited educational or vocational institution on a full-time basis.

208 **Surviving Dependents.** ~~Child Dependents and Handicapped Dependents~~**Dependent.** A deceased
209 insured Employee's or a deceased insured Retiree's Child Dependent, who, younger than 19
210 years of age, the Child had no surviving parent.

211 **Surviving Spouses**~~Spouse.~~ A widow or widower of an insured ~~Employees, Municipal Insureds,~~
212 ~~Retirees~~Employee or ~~insured Surviving Spouses.~~

213 ~~Surviving Spouses. Widows and widowers of insured Employees, Municipal Insureds, Retiree,~~
214 ~~until death~~ or ~~Retirees-remarriage.~~ Persons divorced or legally separated from insured Employees
215 or Retirees are not Surviving Spouses.

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Survivor. A Surviving Spouse or Surviving Dependent.

Chapter 5.00.

References and Annotations

REGULATORY AUTHORITY

805 CMR 5.00: ~~M.~~G.L. c. 32A, § 3.

CMR T. 805, Ch. 5.00, Refs & Annos, MA ADC T. 805, Ch. 5.00, Refs & Annos

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§ 5.01: Relationship of Department Heads, The Commission and Employees

The Commission has the exclusive responsibility to negotiate all contracts for benefits authorized by ~~M.~~G.L. c. 32A, G.L. c. 32B, §§ 19 and 23, and accompanying regulations. Department heads, including agency heads, reporting location heads, and Group Insurance Coordinators are required to conduct all matters relating to Commission programs described in 805 CMR 5.00 with the Commission unless the Commission's Executive Director gives prior approval.

§ 5.02: Solicitation of Employees

External persons and entities must obtain prior written approval of the Commission's Executive Director to discuss Commission matters with individual employees or groups of employees. If approval is given, group meetings or discussions shall only be conducted at the employees' workplace during duty hours and are subject to the department or agency head's prior approval.

(1) All informational gatherings held for potential Municipal Insureds and Municipal Employers must ~~invite~~include representatives of all of the Commission's health plans that serve the area to attend the gatherings to the extent that such meetings are attended by any ~~other~~ health plan representatives.

(2) Health Plans, insurance carriers, agents, brokers or representatives are prohibited from advertising to or soliciting any benefit plans or programs to groups for whom the Commission is the exclusive sponsor. Entities with Commission benefits must offer to their employees, retirees, and survivors all such benefits for which their Insureds are eligible, and may not offer competing benefits, except where expressly authorized in statute. After written notice to the Commission, Municipal Employers and Municipal Insureds who are considering withdrawal from Commission

Health Coverage may advertise for or solicit such plans or programs in order to procure other health coverage after withdrawal. Any person or entity that the Commission determines has violated the provisions of 805 CMR 5.02 shall be ineligible to bid on Commission business for a period of up to five years.

§ 5.03: Participation of Non-state Funded Employers Other than Municipal Employers

~~Non~~Other than Municipal Employers, non-state funded employers whose employees ~~or~~, retirees, or survivors participate in Commission coverage as expressly mandated by state law shall directly reimburse the Commission for premium payments made on behalf of the employers' Insureds, together with an administrative ~~expenses-fee~~. Reimbursing entities shall pay the Commission no later than 90~~30~~ days from the date of the Commission's invoice. The Commission may include in its administrative ~~expense~~fee a charge determined by the State Comptroller for late payment. Such late charge shall be billed separately and identified on a subsequent Commission invoice.

§ 5.04: Providers and Benefits

(1) A participating Nurse Practitioner operating within the scope of his or her license, including all regulations requiring collaboration with a physician under ~~M~~.G.L. c. 112, § 80B, shall be considered qualified as primary care providers for the Commissions' Insureds. Health Plans that fail to comply with the law's provisions will be deemed a prima facie violation of the Consumer Choice of Nurse Practitioner Services Act and a breach of its contract with the Commission, subject to a fine or other such remedies as the Commission determines to be reasonable.

(1A) A participating Physician Assistant operating within the scope of his or her license, including all regulations requiring collaboration with a physician under G.L. c. 112, § 9E, shall be considered qualified as primary care providers for the Commissions' Insureds. Any Commission health plan that fails to comply with the provisions of G.L. c. 176S will be deemed to have violated the Consumer Choice of Physician Assistant Act and to have breached its contract with the Commission, subject to a fine or other such remedies as the Commission determines to be reasonable.

(2) Health plans that require Insureds to designate a primary care provider shall provide clear and concise information to Insureds that they may select a participating Nurse Practitioner or Physician Assistant as a primary care provider or may change their medical provider to a participating Nurse Practitioner ~~- or Physician Assistant~~. Insureds' Evidence of Coverage shall also contain a clear, concise and complete statement that the carrier will provide benefit coverage

282 to subscribers on a Nondiscriminatory Basis for covered services when delivered or arranged for
283 by a participating Nurse Practitioner or Physician Assistant.

284 (3) Notwithstanding any general or special law to the contrary, the Commission's health plans
285 shall include and make available to Insureds the same type of information about participating
286 Nurse Practitioners or Physician Assistants as they provide about their participating physicians,
287 and shall display the participating Nurse Practitioner and Physician Assistant information in the
288 same manner and format as they do for their participating physicians.

289

Chapter 7.00.

References and Annotations

REGULATORY AUTHORITY

805 CMR 7.00: ~~M.~~G.L. c. 32A, § 3.

CMR T. 805, Ch. 7.00, Refs & Annos, MA ADC T. 805, Ch. 7.00, Refs & Annos

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§7.01: Retired Municipal Teachers: In General

(1) A Local Governmental Unit that accepts ~~M.~~G.L. c. 32B, § 11E shall inform the Commission in writing of its decision to transfer its retired teachers to the Commission's Health Coverage for Retired Municipal Teachers.

(2) Upon receiving the Local Governmental Unit's acceptance notice, the Commission shall consider applications from the Local Governmental Unit and shall notify the Local Governmental Unit's treasurer that the Commission has approved the coverage transfer. Thereafter, the Local Governmental Unit shall promptly notify all teachers whom it employs that they must be enrolled in the Local Governmental Unit's basic life insurance upon retirement in order to be eligible for the Commission's life insurance and Retired Municipal Teacher health coverage.

(3) Eligible retiring teachers or their surviving spouses, as applicable, who apply when first eligible to be insured in the Retired Municipal Teachers' Program, must complete a Commission application in order to avoid a lapse in coverage. Teachers shall complete and submit their applications to the Commission approximately three months before their anticipated Coverage effective date determined by the Commission.

(4)(a) Retiring teachers whose Local Governmental Unit participates in the Commission's Retired Municipal Teacher program are required to be insured with the Local Governmental Unit upon Retirement in order to be eligible for Commission coverage.

(b) The Local Governmental Unit providing Retired Municipal Teacher coverage shall provide a notice to all newly hired teachers informing them that they must be enrolled in the Local Governmental Unit's life or life and health coverage at retirement in order to be eligible for Retired Municipal Teacher coverage. The Local Governmental Unit shall allow teachers who have a right to retire but defer their retirement to maintain their eligibility by continuing to be insured for Basic Life Insurance or Basic Life and Health Insurance.

(5) Teachers from a Local Governmental Unit that decides to join Health Coverage pursuant to M.G.L. c. 32B, § 19 are considered to be Retired Municipal Teachers only if their retirement date occurs before July 1st of the year in which the teachers' Local Governmental Unit joins Health Coverage.

(6) Retired teachers who decline Retired Municipal Teacher coverage when they are first eligible may later enroll only during annual enrollment or with satisfactory proof of loss of other health coverage. The Local Governmental Unit must certify to the Commission that the Retired Municipal Teacher was insured at retirement in the Local Governmental Unit's life or life and health coverage.

§ 7.02: Transfer Procedures, Effective Date of Insurance

(1) The Commission shall contact retiring teachers about their applications for Retired Municipal Teacher coverage, and shall determine their effective dates of coverage. The Local Governmental Unit shall continue to be responsible for providing the retiring teachers' premium contributions to their Local Government Unit coverage until such time as their Retired Municipal Teacher coverage becomes effective. ~~The Commission shall send applications to Retired Municipal Teachers with other coverage materials.~~

(2) The Local Government Unit must process Retired Municipal Teacher coverage as follows:

(a) The Local Governmental Unit shall continue to collect premium payment from the retired teachers or their surviving spouses, as applicable, until the Commission ~~receives~~sends notice that premium payment has been transferred to pension deduction.

(b) The Local Governmental Unit shall furnish Commission applications to all retiring teachers; ~~including those who do not currently have, at the Local Governmental Unit's time of retirement, are enrolled in~~ life insurance coverage or life and health ~~benefits~~insurance coverage, along with the notice described in 805 CMR 7.01(2), three months prior to their expected retirement date.

(c) The Local Governmental Unit shall continue to collect retiring teachers' premium for two Calendar Months following the month in which the teacher retires. The first day of the third Calendar Month following the month in which a teacher retires, or a date otherwise determined by the Commission, is the retired teacher's coverage effective date, provided that the retiree pays the required monthly premium for coverage. The Commission shall notify the Local Governmental Unit of all retirees' effective dates of Commission coverage.

§7.03: Correction of Incorrect Premium Payment

(1) If a Local Governmental Unit continues to bill a retiring teacher and also receives premium payment after the retiring teacher's effective date of Commission coverage, the Local Governmental Unit shall refund the payment to the retiring teacher upon satisfactory proof of payment.

(2) If a Local Governmental Unit ceases billing a retiring teacher before his or her Retired Municipal Teacher's coverage effective date, creating a premium payment lapse, the Local Governmental Unit shall bill the teacher for past and current premium due until the Commission notifies the Local Governmental Unit to discontinue billing.

(3) If the Commission's premium is not deducted from the retiring teacher's pension or annuity, the Commission shall bill the teacher directly until the premium has been deducted. Failure to pay the required premium on time shall result in termination of coverage.

§ 7.04: Coverage Options

The Commission shall determine the health coverage options available to Retired Municipal Teachers.

§ 7.05: Termination of Retired Municipal Teacher Status

(1) If the Local Governmental Unit subsequently withdraws from Commission coverage, all Retired Municipal Teachers will cease to be eligible for the Commission's Retired Municipal Teacher coverage. The Commission and the Local Governmental Unit shall jointly determine the termination effective date.

(2) Retired Municipal Teachers whose Local Governmental Unit agrees to join the Commission's Health Coverage pursuant to ~~M.~~G.L. c. 32B, § 19 cease to be Retired Municipal Teachers and, in so doing, their Commission's Basic Life Insurance and Retiree Dental Coverage ends ~~as of July 1st of~~ on the year-in date on which the Municipal Employer joins the Commission's Health Coverage.

(3) A Local Governmental Unit that decides to join Health Coverage pursuant to ~~M.~~G.L. c. 32B, § 19 must continue to contribute its premium share to Retired Municipal Teacher coverage until the date that all of the Local Governmental Unit's insureds begin their Health Coverage.

388 | Chapter 8.00. Coverage for G.L. c. 32B Entities

389

~~Chapter 8.00.~~

References and Annotations

REGULATORY AUTHORITY

805 CMR 8.00: ~~M.~~G.L. c. 32B, §§ 19, 21, and 23.

CMR T. 805, Ch. 8.00, Refs & Annos, MA ADC T. 805, Ch. 8.00, Refs & Annos

Current through April 13, 2012, Register #1206

§ 8.01: Transfer Procedures

The Commission shall determine whether a Municipal Employer that has adopted G.L. c. 32B, §§ 19 or 23, qualifies for the Commission's Health Coverage. If the Commission approves a Municipal Employer to transfer all of its ~~insureds and dependents~~Insureds whom the Commission determines to be eligible to join the Commission's Health Coverage, it shall do so according to the conditions set forth in ~~M.~~G.L. c. 32B, ~~§§§~~ 19, 21, and 23.

(1) Notice. Non-unionized cities, town and districts must send a letter from their chief executive officer stating their decision to transfer the Municipal Employer's subscribers to Commission coverage. Unionized Municipal Employers must provide notice as follows:

(a) Section 19 Notice. For the purposes of notice to the Commission of intent to transfer subscribers sufficient to satisfy G.L. c. 32B, § 19 (e), Unionized Municipal Employers must provide to the Commission a copy of the signed and executed ~~bargained~~Public Employee Committee agreement to join the Commission's health coverage and a cover letter from an authorized official of the Municipal Employer confirming the Municipal Employer's intent to join Commission Health Coverage. ~~Non-unionized Commonwealth Charter Schools must provide a certified copy of the majority vote of their board of trustees to join Commission health coverage; non-unionized Education Collaboratives must provide a certified copy of their boards of directors' majority vote to join Commission coverage. Regional planning agencies and regional councils of government must provide a letter from their governing board stating their decision to join Commission coverage, and non-unionized cities, town and districts must send a letter from their chief executive officer stating their decision to transfer the Municipal Employer's subscribers to Commission coverage.~~The notice deadline may be extended up to a maximum of five business days after the statutory deadline for the sole purpose of executing the Public Employee Committee agreements.

(2)b) Section 23 Notice. For the purposes of notice to the Commission of intent to transfer subscribers sufficient to satisfy G.L. c. 32B, § 23 (a), Unionized Municipal Employers ~~who have negotiated, ratified~~must provide to the Commission a copy of the signed and executed an

~~agreement with the Public Employee Committee to transfer to Commission Health agreement, or the order of the three-person panel, under G.L. c. 32B, § 21, to join the Commission's health coverage must file the executed agreement incorporating all terms of coverage, a copy of the proposal underlying the order of the three-person panel, where applicable, and payment arrangements as the Employees' notice by the deadline. The Commission shall determine a cover letter from an authorized official of the Municipal Employer's effective date of Employer that gives notice of a decision to transfer to the Commission Health Coverage. The agreement or the order and supporting proposal shall include the premium contribution details.~~

(32) A Municipal Employer's transfer agreement or order whose terms ~~significantly~~ alter the Commission's Health Coverage benefit levels from those determined by the Commission or subsidize Municipal Insureds' health coverage are prohibited, with the exception of Municipal Employers funding pre-tax program start-up costs and annual administrative fees, Medicare Part B premium refunds and such other exceptions as are expressly authorized by law. Prohibited alterations include but are not limited to the following:

(a) Alteration of its subscribers' choice of health carriers, health benefits, or out-of-pocket costs;

(b) Offering ~~health benefits or compensation for health benefits not otherwise provided to other non-Commission subscribers~~ health insurance coverage;

(c) Making contributions to offset Commission health premium or specific health benefits, including compensating the difference between current municipal benefits and Commission benefits, except as expressly authorized by law, including as authorized by G.L. c. 32B, §§ 24 and 25;

(d) Obligating the Commission's municipal coverage to pay for health claims that were incurred ~~but not reported~~ before the Municipal Insureds' Commission coverage became effective.

Such alterations or subsidies are grounds for rejection or termination from Commission coverage after a 90-day termination notice. In the event that the Commission learns of the violation after Commission coverage has begun, termination shall be retroactive to the initial subsidy or alteration.

(3) Scope of Transfer. Upon the Municipal Employer's coverage effective date and for the duration of its coverage with the Commission, the Municipal Employer shall not provide any non-Commission health coverage to its employees.

(4) Coverage Effective Date. Health Coverage for Municipal Insureds shall begin on the effective date of transfer as determined by the Commission. The Commission's Health Coverage shall consider only health care claims that are incurred after the Commission's effective date of transfer. The Municipal Employer shall be solely responsible for continuing its Municipal

Insureds' health coverage until the effective date of transfer to Municipal Coverage, including coverage of any costs or claims incurred but not reported prior to the effective date of transfer.

(5) Enrollment, Choice of Plans. As of the effective date of transfer to the Commission's Health Coverage, the Municipal Employer shall provide the Commission's forms for Health Coverage enrollment to all prospective insureds, including those who currently are not enrolled in the Municipal Employer's health coverage. Municipal Employer Insureds shall be offered all of the health plan choices as are offered to other Insureds who live in the same geographic area.

(6) Data Required with Notice. A Municipal Employer that has given notice as defined in clause (1) of this section of its decision to transfer shall provide the Commission with a completed "Required Municipal Initial Enrollment Data" of its current enrollee population for whom it provides health insurance coverage. These data shall be provided no later than 30 days after the notice deadline for any given enrollment period and be in a format designated by the Commission. The Commission shall provide the file type, file layout, data elements and the Commission's Municipality Software Application upon request of the Municipal Employers. The Commission will publicize initial enrollment data requirements on its website.

(a) Completeness of the aggregated data shall be assessed by use of the Commission's Municipality Software Application and shall be within a five percent error threshold.

(b) The total count of eligible subscribers, including all employees, retirees, and survivors who would be eligible for Commission health insurance whether or not currently enrolled shall be provided by the deadlines as described above.

(c) All Municipal Employers shall provide the Commission with the following contact information:

(i) IT contact and alternate;

(ii) benefits coordinator and alternate;

(iii) fiscal contact and alternate; and

(iv) authorized official and alternate.

Contact information shall include mailing address, phone number and email address.

(d) All Municipal Employers shall provide their benefits coordinator staff with internet access to utilize the Commission's eligibility system (known as the MAGIC system). The Commission shall provide authentication certificates, user IDs and passwords to allow access to the MAGIC system.

(7) The Municipal Employer shall provide, in advance, a draft to the Commission of the initial subscriber communication, which will be subject to the Commission's review. The Commission

shall provide a template for this communication. Future communications regarding the Commission shall be cleared by the Commission in advance of their distribution. The Commission shall provide a master premium contribution chart for the Municipal Employer to use in developing a customized rate chart for its own contribution ratios as well as all benefit related materials. The Municipal Employer shall produce customized rate charts for its subscribers and shall provide them to the Commission in an Americans with Disability Act (ADA) accessible format for the Commission's website.

(8) Municipal Employers that do not meet the Commission's required deadlines during the implementation period may, at the Commission's sole discretion, have their coverage effective date delayed until the next scheduled enrollment period.

(9) If a Municipal Employer chooses to transfer to Commission coverage and its retired teachers currently receive insurance through the Commission's Retired Municipal Teachers program under G.L. c. 32A, § 12, all said retired teachers shall transfer from the Commission's fully insured Pool 2 to Pool 1 and may re-enroll in Commission benefits for which they are eligible. Retired Municipal Teachers who transfer to the Commission through their respective Municipal Employers may receive through the Commission only those benefits for which they are eligible under c. 32B, §§ 19 or 23, as applicable, and are no longer eligible for Commission life insurance.

(10) Municipal Employers whose teachers have participated in the Commission's Retired Municipal Teacher program immediately prior to transferring to the Commission's Municipal Insureds' Health Coverage must offer their Retired Municipal Teachers basic life insurance upon transfer to Municipal Health Coverage.

§ 8.02: Health Coverage Payments

(1) The Commission shall determine the full cost rates for Health Coverage, ~~which includes the administrative fee determined by the Commission,~~ to be shared by the Municipal Employer and Municipal Insureds. The full cost rates shall consist of a premium cost and an administrative fee determined by the Commission. The administrative fee shall not exceed 1 percent of the premium cost.

(2) The Municipal Employer shall arrange for all Municipal Insureds' premium contributions to be deducted from their paychecks or retirement allowance one month in advance of coverage ~~or through the Municipal Employer's billing system, as the case may be. The~~

(3) No later than March 1, the Municipal Employer shall notify the Commission of any change to Municipal Insureds' premium contribution ratios ~~by no later than January 15th. Changes to become~~ contribution ratios shall be effective ~~the following~~ July 1st.

(34) The Municipal Employer shall transmit monthly to the Commission ~~monthly~~ the full cost of Municipal Insureds' Health Coverage, including the applicable administrative fee. ~~The administrative fee shall be considered as part of the cost of Health Coverage, and shall not exceed 1% of the total premium cost.~~

~~(4) The Municipal Employer must pay premium one month in advance of Commission coverage, and must pay the full cost premium, including the applicable administrative fee, in full and on time. Payment of Municipal Insureds' Health Coverage is due on a date determined by the Commission. The Commission shall bill-invoice the Municipal Employer on a quarterly reimbursement basis, due 30 days from monthly billing cycle for the invoice date. The Municipal Employer shall provide to the Commission, on a quarterly basis the full cost health insurance premium contribution ratio paid by liability and administrative fee. Invoices will be sent electronically, via secure email, to each Municipal Insured in a format prescribed by the Commission. Employer each month; any adjustments will be separately noted on the following month's invoice.~~

(a) In the event that a Municipal Employer fails to pay the cost of its Insureds' Health Coverage within 30 days of the premium due date, the Commission shall send an overdue notice to the Municipal Employer. ~~If payment is~~ Payments not ~~made~~ received after ~~60~~ 30 days' delinquency, ~~it may will~~ be subject to interest charges and further action.

(b) The Commission shall notify the Public Employee Committee ~~and~~, the Municipal Employer, and the Executive Office for Administration and Finance of the delinquency and the Commission's intention to cancel ~~the Municipal Insureds' Health Coverage~~ coverage if the Municipal Employer fails to pay the full amount in arrears for more than 60 ~~consecutive~~ days ~~following from~~ the premium invoice due date.

~~(c) As to remaining arrearages, the Commission may inform the state treasurer who shall issue a warrant in the manner provided by G.L. c. 59, § 20 requiring the Municipal Employer to pay into the treasury, as prescribed by the Commission, the amount of the premium and administrative expenses attributable to the political subdivision, see G.L. c. 58, § 20A.~~

~~(ed)~~ If any amount remains in arrears at the end of ~~the 60a~~ 90-day period, the Commission ~~shall cancel~~ may begin termination proceedings of the Municipal Employer's ~~Commission Health Coverage~~ health coverage, and the Municipal Employer ~~shall~~ may be responsible for all claims incurred during the period in which the full premium was not paid.

~~§(5) If a Municipal Employer fails to notify the Commission within 60 days of a termination or other loss of eligibility due to a change in employment status, the Commission may assess against the Municipal Employer a financial penalty of \$100 per ineligible person per month, or~~

the amount by which actual claims for any ineligible person exceeded premiums paid by the Municipal Employer for that person, whichever is greater.

§ 8.03: Eligibility. Conditions of Participation

(1) To be eligible for Health Coverage, persons affiliated with Municipal Employers must be Employees, Retirees, Survivors, or Dependents, as those terms are defined in §1.02.

(2) For the purposes of implementing G.L. c. 32B, §§ 19 and 23, the Commission interprets G.L. c. 32B, §§ 19(a) and (e) and §23(h) to mean that eligibility for Health Coverage in political subdivisions that have transferred subscribers to the Commission pursuant to §§ 19 or 23 remains subject to G.L. c. 32B. However, for those political subdivisions, the Commission is the sole determinant of who is eligible for Health Coverage. The Commission interprets eligibility under G.L. c. 32B to be the same as eligibility under G.L. c. 32A, except where there is a clear distinction between the two chapters. Therefore:

(a) Consistent with § 9.08 and the definitions of Employee and Retiree in § 1.02, the employees and retirees of a city, town, regional school district, or any other statutorily authorized district shall not be eligible for Commission coverage unless they are members of a Massachusetts public sector retirement system, are receiving a pension from a public retirement system, or are Survivors of Municipal Employees or Retirees (OBRA is not such a public retirement system for this purpose).

(b) Municipal Employees, except elected officials or others as expressly exempted by law, must meet the requirement of a Regular Work Week, as defined in §1.02. For the purposes of G.L. c. 32B, §§ 19 and 23, the reference to “20 hours” in G.L. c. 32B, § 2, “Employee” means 20 hours out of a regular work week of 40 hours, or 18.75 hours out of a regular work week of 37.5 hours.

(3) The following individuals are Municipal Employees:

(a) Elected officials, without regard to hours worked or to participation in a pension system, are Municipal Employees at local option, consistent with § 9.02 and G.L. c. 32B, § 2, “Employee.”

(b) Members of call fire departments or other emergency services, without regard to hours worked, are Municipal Employees at local option, consistent with G.L. c. 32B, § 2, “Employee.”

(c) Public school employees are deemed to be Employees during the months of July and August, without regard to hours worked.

(d) Traffic supervisors, without regard to hours worked, are Municipal Employees at local option, consistent with G.L. c. 32B, § 2A.

(e) Reserve, permanent-intermittent, and call firefighters, without regard to hours worked, are Municipal Employees and, upon retirement, Municipal Retirees, at local option, consistent with G.L. c. 32B, § 2B.

~~(4)~~ The Commission shall determine the effective date for all matters pertaining to Municipal Insureds' ~~and their eligible dependents'~~ Health Coverage, including but not limited to their eligibility, effective dates of coverage, termination, and status changes. The Commission determines whether persons are eligible for Commission coverage as Municipal Insureds according to ~~M~~-G.L. c. 32A and 32B, and its eligibility decisions are final and binding. Prior coverage through a Municipal Employer does not guarantee Commission coverage.

~~(25)~~ Municipal Employers that do not meet the Commission's required deadlines during the implementation period may, at the Commission's sole discretion, have their coverage effective date pending until such time as the Commission can determine an appropriate date.

~~(36)~~ The Municipal Employer shall submit all eligibility and enrollment information requested by the Commission, including census data in a format specified by the Commission, along with documentation that the Commission deems necessary to determine eligibility.

~~(47)~~ A Municipal Employer's authorized individual shall certify the accuracy of the eligibility information and shall submit the certification, signed under the pains and penalties of perjury, with the eligibility data for the Commission's review and decision. No persons shall be enrolled in Commission coverage without the prior approval of the Commission.

~~(58)~~ Surviving Spouses of Municipal ~~Insureds~~Employees and Municipal Retirees are eligible for Commission coverage, subject to the provisions of 805 CMR 9.09.

~~(6)~~ Health Coverage for Municipal ~~Employers'~~Employees' and Retirees' surviving spouses ends upon the surviving spouse's remarriage.

~~(79)~~ Municipal Insureds and their eligible dependents shall be eligible for Health Coverage and shall be subject to the same Health Coverage terms, conditions, carriers, schedules, benefits and benefit levels as those provided to ~~state~~State Employees ~~and~~, Retirees ~~and survivors~~, Survivors, and their ~~eligible dependents~~Dependents in the pool.

~~(810)~~ The Commission may audit Municipal Employers for compliance with the Commission's policies and procedures for maintaining Municipal Insureds' Health Coverage.

~~(9)~~ ~~Municipal Insureds who~~ 11) If they are ~~retired and become~~ eligible for Medicare Part A for free, Municipal Retirees, their covered spouses, and Municipal Surviving Spouses are required to ~~promptly~~ enroll in Medicare Parts A and B ~~during the next available Medicare annual enrollment~~ in order to receive ~~supplementary~~ health coverage through the Commission. They must enroll during Medicare's next annual enrollment period. Municipal Employers shall be required to notify all retirees of this obligation and of the next Medicare open enrollment period. The

Municipal Employer shall pay any new late entry penalties for its Medicare-eligible Insureds who were required to join Medicare as a condition of transfer to Health Coverage. The Commission shall not pay for or reimburse any Part B premium. Municipal Employers shall reimburse retirees for penalties incurred by their Medicare eligible insureds who are required to join Medicare upon transferring to Commission coverage. A Municipal Employer is not required to reimburse retirees for late enrollment penalties if the retiree did not enroll in Medicare when required.

~~(4012)~~ Upon the Municipal Insureds' Coverage effective date and for the duration of their Health Coverage, the Insureds shall not receive health coverage pursuant to ~~M.G.L. c. 150E~~, ~~M.G.L. c. 32B~~ or any other arrangement with the Municipal Employer.

~~(4113)~~ The Municipal Employer shall perform all administrative functions and shall process and provide all information that the Commission deems is necessary to administer its Insureds' Health Coverage, including monthly billing reconciliation.

(a) The Municipal Employer and its Insureds, as the case may be, shall furnish all information necessary to maintain its Insureds' Health Coverage in such form, content and frequency as the Commission determines, including but not limited to monthly reconciliation of the Commission's monthly billing file.

(b) The Municipal Employer shall gather eligibility information for enrollment and status changes, and forward a copy of all such documentation to the Commission with each application. Any ~~materials that require necessary~~ translation shall be ~~borne~~ at the applicant's or Municipal Employer's expense.

~~(4214)~~ Municipal Insureds who terminate employment while in good premium payment standing and begin employment with benefits with another ~~Municipal~~ Employer before Commission coverage under the prior Municipal Employer ends, shall continue to be insured without a break in existing coverage and must remain in the health plan they enrolled in with the first Municipal Employer. Such Municipal Insureds who begin employment with benefits with another ~~Municipal~~ Employer after Commission coverage under their prior Municipal Employer has ended shall be ~~treated as new employees~~ subject to ~~the required waiting period for coverage~~ § 9.19.

~~(4315)~~ The Commission is not subject to the provisions of ~~M.G.L. c. 30A~~.

(16) Prior to the effective date of transfer to the Commission's health coverage, the Municipal Employer shall distribute enrollment materials, as provided by the Commission, for health coverage enrollment to all prospective Insureds, including those who currently are not enrolled in the said Municipal Employer's health coverage. The Municipal Employer's Insureds shall be offered the same health plan choices offered to state Insureds who reside in the same geographic area.

(17) Coverage ends on the last day of the calendar month following the month that an employee leaves the service of his or her original Municipal Employer. Premiums shall be collected for that last month by the Municipal Employer.

(18) If a former Spouse is eligible under the terms of a divorce decree and enrolled under the insured's family plan, coverage for the former Spouse under the insured's family plan will end upon the remarriage of either the Insured or Spouse. The former Spouse may be eligible for a divorced Spouse rider or COBRA coverage as determined by the Commission depending upon the language in the divorce decree.

§ 8.04: Coverage Continuation and Termination, Notice Deadline

(1) A Municipal Employer that transfers to Health Coverage due to a Fiscal Emergency declared by the Legislature may continue Health Coverage for its insureds after the governing finance control board or receiver determines that a Fiscal Emergency no longer exists or otherwise ends its oversight of the Municipal Employer. If a Municipal Employer remains in Health Coverage after release from finance control board oversight, the Municipal Insureds' Health Coverage shall be subject to the same Commission rules and regulations that apply to Municipal Employers whose ~~insureds~~Insureds have joined Health Coverage pursuant to ~~M.~~G.L. c. 32B, § 19.

(2) If a Municipal Employer terminates Commission coverage without giving notice by the deadline, the Municipal Insureds' Health Coverage shall be cancelled for nonpayment retroactive to the last month for which the Municipal Employer paid its share of the premium.

~~(3) A Municipal Employers whose teachers have participated in the Commission's Retired Municipal Teacher program immediately prior to transferring to the Commission' Municipal Insureds' Health Coverage must offer their Retired Municipal Teachers basic life insurance upon transfer to Municipal Health Coverage.~~

~~(4) Municipal Employers must give notice of its decision to join the Commission's Health Coverage as required by the statutory deadline in the M.G.L. c. 32B, § 19, which can be extended up to a maximum of five business days after the deadline for the sole purpose of executing their ratified Public Employee Committee agreements.~~

~~§ 8.05: Transfer Procedures under M.G.L. c. 32B, § 23~~

~~The Commission shall determine whether any individual municipal subscriber qualifies for the Commission's insurance coverage pursuant to M.G.L. c. 32A, § 2. Under 805 CMR 8.05, "Authority" shall mean Appropriate Public Authority, as defined in M.G.L. c. 32B, § 2. If the Commission approves a transfer of all of an Authority's insureds and dependents whom the~~

~~Commission determines to be eligible to join the Commission's insurance coverage, it shall do so according to the conditions set forth in M.G.L. c. 32B, § 23.~~

~~(1) If an Authority chooses to transfer to the Commission, it shall provide a copy of the signed and executed agreement, or the order of the three-person panel, under M.G.L. c. 32B, § 21, to join the Commission's health coverage, along with a cover letter from an authorized official of the Authority that gives notice of a decision to transfer to the Commission. The said agreement or the order shall include the premium contribution details.~~

~~(2) An Authority that has given notice as defined in 805 CMR 8.05(1), of its decision to transfer shall provide the Commission with a completed "Required Municipal Initial Enrollment Data" of its current enrollee population for whom it provides health insurance coverage. These data shall be provided by the notice deadline for any given enrollment period and be in a format designated by the Commission. The Commission shall provide the file type, file layout, data elements and the Commission's Municipality Software Application upon request of the Authority. (See www.mass.gov/gic under "municipality information" for the Required Municipal Initial Enrollment Data information.)~~

~~(a) Completeness of the aggregated data shall be assessed by use of the Commission's Municipality Software Application and shall be within a five percent error threshold.~~

~~(b) The total count of eligible subscribers, including all employees, retirees, and survivors who would be eligible for Commission health insurance whether or not currently enrolled shall be provided by the notice deadline.~~

~~(c) All Authorities shall provide the Commission with the following contact information:~~

~~1. IT contact and alternate;~~

~~2. benefits coordinator and alternate; and~~

~~3. authorized official and alternate. Contact information shall include mailing address, phone number and email address.~~

~~(d) All Authorities shall provide their benefits coordinator staff with internet access to utilize the Commission's eligibility system (known as the MAGIC system). The Commission shall provide authentication certificates, user IDs and passwords to allow access to the MAGIC system.~~

~~(3) The Authority shall provide, in advance, a draft to the Commission of the initial subscriber communication, which will be subject to the Commission's review. The Commission shall provide a template for this communication. Future communications regarding the Commission shall be cleared by the Commission in advance of their distribution. The Commission shall provide a master premium contribution chart for the Authority to use in developing a customized rate chart for its own contribution ratios as well as all benefit related materials. The Authority~~

~~shall produce customized rate charts for its subscribers and shall provide them to the Commission in an ADA-accessible format for the Commission's website.~~

~~(4) Authorities that do not meet the Commission's required deadlines during the implementation period may, at the Commission's sole discretion, have their coverage effective date delayed until the next scheduled enrollment period.~~

~~(5) The employees and retirees of a city, town, regional school district, charter school or any other statutorily authorized district shall not be eligible for Commission coverage unless they are members of a Massachusetts public sector retirement system, are receiving a pension from a public retirement system, or are survivors of members (OBRA is not such a public retirement system for this purpose).~~

~~(6) Upon the Authority's coverage effective date and for the duration of its coverage with the Commission, said Authority shall not provide any non-Commission health coverage to its employees except those subscribers for whom the Authority is obligated to provide health insurance coverage pursuant to M.G.L. c. 150E. Where an Authority has subscribers whose health insurance coverage is provided pursuant to a collective bargaining agreement and includes plan design features that are inconsistent with those of the Commission's coverage, then the Authority shall not transfer these subscribers to the Commission under M.G.L. c. 32B, § 23 until the end of the initial term of the agreement. With regard to the eligible subscribers still covered under collective bargaining agreements, where there are one or more differing end dates of their respective collective bargaining agreements, all such subscribers shall transfer to the Commission on July 1st of any given fiscal year.~~

~~(7) Authorities~~Employer transferring out of the Commission's coverage pursuant to ~~M.G.L. c. 32B, §§ 19 or 23~~ shall provide the Commission with notice on or before October 1st for transfer on ~~June 30th~~July 1 of the following year, ~~and all of the Authority's subscribers shall be transferred out on that date.~~ The effective date for ~~an Authority~~a Municipal Employer to withdraw from Commission coverage shall be on ~~June 30th~~July 1 of the expiration year as specified in a municipal entity's bargained agreement or Order of the Panel, and Commission coverage shall end on June 30.

~~(8) Health coverage for said Authorities' insureds shall begin on the effective date of transfer as determined by the Commission. The Commission's health coverage shall only apply to health care claims that are incurred on or after the effective date of transfer to the Commission. The Authority shall be solely responsible for continuing its insureds' health coverage until the effective date of transfer to the Commission, including coverage of any costs or claims incurred but not reported prior to the effective date of transfer.~~

~~(9) Prior to the effective date of transfer to the Commission's health coverage, the Authority shall distribute enrollment materials, as provided by the Commission, for health coverage enrollment to all prospective Insureds, including those who currently are not enrolled in the said Authority's~~

~~health coverage. The Authority's Insureds shall be offered the same health plan choices offered to state Insureds who reside in the same geographic area.~~

~~(10) The Authority's insureds shall be eligible for the Commission's health coverage and shall be subject to the same health coverage terms, conditions, carriers, schedules, benefits and benefit levels as those provided to state Insureds. Changes in eligibility and effective dates will be determined by the Commission. Prior coverage through the Authority does not guarantee Commission coverage unless the Commission's eligibility requirements are met.~~

~~(11) Eligible Employees who apply for coverage within ten days of employment shall be insured either within 60 calendar days or two calendar months from said first day of employment, whichever is earlier. The first day of employment shall be counted when determining the effective date of Commission coverage, and one or more days of authorized leave of absence shall be counted as an equivalent number of days of employment.~~

~~(12) Coverage ends on the last day of the calendar month following the month that an employee leaves the service of his or her original Authority. Premiums shall be collected for that last month by the Authority.~~

~~(13) All Authorities with Commission coverage shall be required to take monthly deductions for enrollees one month in advance, and shall remit to the Commission on the required schedule.~~

~~(14) All Authorities shall be required to cover eligible surviving Spouses of enrollees. Surviving Spouses shall be eligible for Commission coverage, but coverage of a surviving Spouse shall end upon the surviving Spouse's remarriage.~~

~~(15) If a former Spouse is eligible under the terms of a divorce decree and enrolled under the insured's family plan, coverage for the former Spouse under the insured's family plan will end upon the remarriage of either party. The former Spouse may be eligible for a divorced Spouse rider or COBRA coverage as determined by the Commission depending upon the language in the divorce decree.~~

~~(16) Authorities' insureds who transfer to Commission coverage and are retired and eligible for Medicare shall be required to enroll in Medicare Parts A and B during the next available Medicare annual enrollment in order to receive health coverage through the Commission.~~ (4) A Municipal Employer that withdraws from Commission coverage and does not immediately transfer its Insureds to the Commission pursuant to a different section of c. 32B may not transfer its Insureds to the Commission for three years. For example, a Municipal Employer may withdraw from Commission coverage pursuant to G.L. c. 32B, § 19 effective July 1 and transfer its Insureds to Commission coverage pursuant to G.L. c. 32B, § 23, as of the same July 1. However, if it does not do so, but instead withdraws from all Commission coverage, it may transfer its Insureds once again to the Commission no earlier than July 1, three years after the effective date of the earlier withdrawal.

No § 8.05

§ 8.06 Data Management and Communication

~~(1) Municipal Employers Municipal Employers shall be required to notify all retirees of this obligation and of the next Medicare open enrollment period. Authorities shall not bill the Commission for any Part B premiums or late enrollment Part B penalties. Authorities shall reimburse retirees for penalties incurred by their Medicare eligible insureds who are required to join Medicare upon transferring to Commission coverage. The Authority is not required to reimburse retirees for late enrollment penalties if the retiree did not enroll in Medicare when required.~~

~~(17) Authorities shall gather eligibility information for enrollment and status changes, and shall forward a copy of all such documentation to the Commission. Any costs for materials that require translation shall be borne at the applicant's or Authority's expense.~~

~~(18) Authorities' insureds who terminate employment while in good premium payment standing and begin employment with benefits with another Commission Authority before coverage ends with the initial employer, shall continue to be insured without a break in coverage and must remain in the health plan they enrolled in with the first Authority. Said Insureds who began employment with benefits provided through another Municipal Employer after prior Commission coverage has ended, shall be treated as new employees subject to the required waiting period for coverage.~~

~~(19) The Commission shall determine the full cost rates for health coverage, which includes the administrative fee determined by the Commission, to be shared by the Authority and its insureds.~~

~~(20) The Authority shall arrange for all its insureds' premium contributions to be deducted from their paychecks or retirement allowance one month in advance of coverage or through the Authority's billing system, as the case may be. The Authority shall notify the Commission of any change to its Insureds' premium contribution ratios by no later than January 15th to become effective the following July 1st.~~

~~(21) The Authority shall transmit to the Commission monthly the full cost of its Insureds' health coverage, including the applicable administrative fee.~~

~~(22) The Authority shall pay premium monthly for Commission coverage, and shall include the applicable administrative fee, in full. Payment of the Authority's Insureds' health coverage is due on a date determined by the Commission. The Commission shall invoice the Authority on a monthly billing cycle for the full cost health insurance premium liability and administrative fee.~~

~~Invoices will be sent electronically (via secure email) to each Authority each month; any adjustments will be separately noted on the following month's invoice. The Authority shall provide to the Commission, on a monthly basis, the premium contribution ratio paid by each of its Insureds in a format prescribed by the Commission.~~

~~(a) In the event that an Authority fails to pay the full amount within 30 days of the invoice due date, the Commission shall send an overdue notice to the Authority. Payment not received after 30 days' delinquency will be subject to interest charges and further action.~~

~~(b) The Commission shall notify the Authority and the Executive Office for Administration and Finance of the delinquency and the Commission's intention to cancel coverage if the Authority fails to pay the full amount in arrears for more than 60 days from the invoice due date.~~

~~(c) As to remaining arrearages, the Commission may inform the state treasurer who shall issue a warrant in the manner provided by M.G.L. c. 59, § 20 requiring the Authority to pay into the treasury, as prescribed by the Commission, the amount of the premium and administrative expenses attributable to the political subdivision, see M.G.L. c. ~~58, § 20A.~~~~

~~(d) If any amount remains in arrears at the end of a 90-day period, the Commission may begin termination proceedings of the Authority's health coverage, and the Authority shall be responsible for all claims incurred during the period in which the full premium was not paid.~~

~~(23) Authorities~~ shall report all changes to an enrollee's coverage on forms designated by the Commission. Upon notification from the Commission, ~~Authorities~~Municipal Employers shall be required to enter on the Commission's eligibility system (MAGIC system), an enrollee's coverage and/or coverage changes.

~~(24)~~ The Commission determines the effective date of enrollees' coverage changes including, but not limited to: individual to family, family to individual, and cancellation of coverage and shall notify the ~~Authority~~Municipal Employer directly via the Premium Deduction Change Notice. The ~~Authority~~Municipal Employer shall accept this notice and update its records accordingly.

~~(25) The Authorities~~(3) Municipal Employers shall reconcile their entire insured membership on a monthly basis via the Statement of Verification that is included with the monthly bill and roster. ~~Authorities~~Municipal Employers shall report any discrepancies to the Commission at a time determined by the Commission. Late notification of discrepancies to the Commission may result in a delay in the effective date of insurance coverage changes.

~~(264)~~ Any ~~Authority~~Municipal Employer that transfers its insureds to the Commission with more than one enrollee percentage contribution towards a particular individual, family or Medicare health plan premium shall ~~be required to~~ provide the Commission with enrollment data by enrollee percentage contribution for said health plan(s) ~~each month on a form that will be~~

~~provided by the Commission. This requirement does not apply to an Authority that has only two enrollee percentage contributions towards a particular individual, family or Medicare health plan premium and where one of the two percentage contributions is exclusively for those enrollees who had formerly participated in the Commission's Retired Municipal Teachers program.).~~
Reporting shall be monthly, or less frequently as required by the Commission, on a form that will be provided by the Commission.

~~(27) If an Authority chooses to transfer to Commission coverage and its retired teachers currently receive insurance through the Commission's Retired Municipal Teachers program under M.G.L. c. 32A, § 12, all said retired teachers shall transfer from the Commission's fully insured Pool 2 to Pool 1 and shall re-enroll in a Commission health plan when an Authority transitions to the Commission. Retired Municipal Teachers who transfer to the Commission through their respective Authorities shall no longer be eligible for the Commission's life or retiree dental insurance coverage, and shall receive only health insurance through the Commission.~~

~~(28) The Commission shall not assume responsibility for any administration relating to municipal health reimbursement arrangements, or any other type of healthcare spending accounts for Authorities transferring to the Commission's coverage. Authorities that establish health reimbursement arrangements under M.G.L. c. 32B, § 25 shall not be subject to the prohibitions of 805 CMR 8.01(3).~~

~~(29) A participating Authority~~(5) A participating Municipal Employer may request data for the sole purpose of determining whether it will continue to participate after three years, as specified in its executed bargained agreement or order from the three person arbitration panel. Requests for such data shall be made in the preceding or current fiscal year in which a given agreement is open to negotiation, and such requests shall be limited to one request in the preceding or current fiscal year in which a political subdivision is considering withdrawing from coverage.

(a) ~~Authorities~~Municipal Employers requesting utilization data should assess the amount of time they will need to analyze data and conduct negotiations before making a decision about whether to remain in the Commission. Such entities must submit their requests to the Commission at least 45 days before the data are to be provided to them to use in their decision-making process. In a City, the request must be signed by the City Manager or the Mayor, in a Town by the Chairman of the Board of Selectmen, and in a regional school district, by the Chairman of the Regional School District Committee.

(b) The Commission will provide the following data to each requesting ~~Authority~~Municipal Employers with more than 50 subscribers:

~~1.~~(i) A monthly claims report consisting of the following data elements:

a. the subscriber count;

909 b. the covered lives count;

910 c. the total paid medical claims;

911 d. the total paid prescription drug claims.

912 | ~~2.~~(ii) A yearly large loss report, i.e., for claimants who have incurred \$25,000 or more paid
913 claims in a given year consisting of the following elements:

914 a. the de-identified claimant ICD-9 codes (diagnoses);

915 b. the de-identified claimant total paid claims (medical and prescription drug).

916 The Commission will provide Protected Health Information to participating
917 | ~~Authorities~~Municipal Employers as the Commission's Business Associates subject to the HIPAA
918 Privacy Rule after each signs the Commission's Business Associate Agreement (BAA).

919 | ~~Authorities~~Municipal Employers that have requested these data will be required to designate a
920 single person to handle these data, and such persons will be required to sign a BAA in which
921 they agree not to share these data with other parties. Before receiving these data, the
922 | ~~Authorities~~Municipal Employers agree to execute a BAA with the Commission in which they
923 agree that only their single designated person shall handle ~~the~~these data, and that ~~the~~these data
924 shall not be shared with anyone other than insurance brokers, benefits consultants, and health
925 plans for the limited purpose of securing bids for the procurement of health insurance.

926 | ~~Authorities~~Municipal Employers wanting Medicare HMO data or fully insured retiree dental
927 coverage data should use the monthly premium as a substitute for actual cost. Administrative
928 costs are not included in the data provided.

929 | ~~Administrative costs are not included in the data provided.~~

930 (306) On or before January 15, 2013 or any later year, at the request of ~~an Authority~~a Municipal
931 Employer, the Commission will make available to the ~~Authority~~Municipal Employer a list of that
932 | ~~Authority's~~Municipal Employer's current members. ~~An Authority~~A Municipal Employer must
933 make any such request by November 15th of the prior year. The purpose of this list is to assist
934 the ~~Authority~~Municipal Employer in meeting its obligations under ~~M.~~G.L. c. 32B, § 26.

935

§ 8.07 Commonwealth Charter Schools, Education Collaboratives, Regional Planning Agencies, and Regional Councils of Government

(1) Eligibility. Employees, Retirees, Survivors, and Dependents of Commonwealth charter schools, education collaboratives, regional planning agencies, or regional councils of government are eligible for Commission benefits if they are statutorily entitled to such benefits pursuant to G.L. c. 32A, § 2(b), or if the Commonwealth charter school, education collaboratives, regional planning agencies, or regional councils of government has adopted G.L. c. 32A as specified in G.L. c. 32A, § 2(b), G.L. c. 32A, § 3B, or G.L. c. 32B, § 21(a), whichever is applicable.

(2) Notice. Non-unionized Commonwealth charter schools must provide a certified copy of the majority vote of their board of trustees to join Commission health coverage; non-unionized Education Collaboratives must provide a certified copy of their boards of directors' majority vote to join Commission coverage. Regional planning agencies and regional councils of government must provide a letter from their governing board stating their decision to join Commission coverage. Unionized Commonwealth charter schools and unionized educational collaboratives must provide the Commission with notice of intent to transfer as required by G.L. c. 32B, § 19 or § 23.

(3) Commonwealth charter schools, education collaboratives, regional planning agencies, or regional councils of government shall follow the transfer protocols in 805 CMR 8.01.

(4) Terms. Except as otherwise stated in this section, Commonwealth charter schools, education collaboratives, regional planning agencies, or regional councils of government who opt to join Commission coverage are subject to applicable requirements of G.L. c. 32A and related regulations.

960 **Chapter 9.00.**

961 *References and Annotations*

962 REGULATORY AUTHORITY

963 | 805 CMR 9.00: ~~M.~~G.L. c. 32A, § 3.

964 | CMR T. 805, Ch. 9.00, Refs & Annos, MA ADC T. 805, Ch. 9.00, Refs & Annos

965 | Current through April 13, 2012, Register #1206

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967 | **§ 9.01: New Employees**

968 | (1) A new Employee's department or agency head shall determine within the first ten days of
969 | employment whether the Employee is eligible for Commission coverage. Employees whose
970 | duties are Seasonal or Emergency Employment or of a duration of not more than three months
971 | with no reasonable expectation of an extension, are not eligible for Commission coverage.
972 | Department or agency heads who are unable to determine eligibility shall send all information
973 | relating to the new ~~Employees'~~Employee's work to the Commission for a final and binding
974 | eligibility determination. Persons who do not enroll in Commission coverage when they are first
975 | eligible may later enroll during the Commission's annual enrollment or upon satisfactory proof of
976 | loss of other coverage. Once an Employee enrolls in a health plan, the next opportunity to change
977 | plans is the GIC's next Annual Enrollment period, except as otherwise required by law.

978 | (2) Members of the Judiciary who qualify as Employees are eligible for Commission coverage.

979 | (3) Effective Date of Insurance Coverage. Eligible Employees who apply for coverage within ten
980 | days of the first day of employment shall be insured on the first day of the month following the
981 | earlier of 60 calendar days or two calendar months from the first day of employment. The first
982 | day of employment shall be counted when determining the effective date of Commission
983 | coverage, and one or more days of authorized leave of absence shall be counted as an equivalent
984 | number of days of employment.

985 | (4) Retroactive Health Insurance Effective Date. Employees-~~or Municipal Insureds~~ or dependents
986 | may request Commission Health Coverage to begin on the first day of employment or the first
987 | day of the health coverage waiting period referenced in 805 CMR 9.01(3), as applicable, if all of
988 | the following conditions are met:

989 | (a) the Employee or ~~Municipal Insured-or~~ Dependent is not enrolled in other health coverage and
990 | incurs an unplanned and urgent medical expense that exceeds the Employee's ~~or Municipal~~
991 | ~~Insured's~~ full cost monthly premium;

992 (b) the unplanned and urgent medical expense occurs on or after the first day of employment or
 993 waiting period but before the effective date of health coverage;

994 | (c) the Employee-~~or Municipal Insured~~ requests such coverage in writing and provides
 995 satisfactory documentation of the unplanned and urgent medical expense.

996 | Coverage shall become effective as of State Employees' first day of active employment or
 997 Municipal ~~Insureds'~~Employees' first day of the waiting period, subject to their timely payment of
 998 the full-cost health insurance premium for the entire hiatus period. New ~~employees~~Employees
 999 who begin employment on the 16th day of a month or later will not be charged premium for that
 1000 month; new ~~employees~~Employees who begin employment on or before the 15th day of a month
 1001 shall be charged the full premium cost for the month. Coverage entitles the Employee only to
 1002 those benefits that are otherwise available through the health plan selected, and claims may be
 1003 denied in whole or in part, consistent with the health plan's covered benefits.

1004 Employees' effective date of life insurance shall only become effective as described in 805 CMR
 1005 9.01(3) or 805 CMR 9.02.

1006 (5) Employer Notification to New Employee. The Employee's department or agency head or
 1007 Group Insurance Coordinator shall inform newly hired employees whether they are eligible for
 1008 Commission coverage and what benefits are available to them, including Consolidated Omnibus
 1009 Budget Reconciliation Act (COBRA) continuation coverage. The Group Insurance Coordinator
 1010 shall also notify newly hired employees that premium deductions for Commission coverage are
 1011 taken one month in advance of coverage.

1012 | (6) New Employees' Duty to Notify Employer. Eligible Employees-~~and Municipal Insureds~~ who
 1013 are advised by their department or agency head that they are eligible for Commission coverage
 1014 shall, within ten days of beginning work or beginning the health care waiting period, inform their
 1015 employer whether they intend to enroll in Commission coverage. Those enrolling in Commission
 1016 | coverage shall ~~thereafter~~ promptly select coverage and complete all necessary forms. Persons
 1017 who fail to enroll in Commission coverage when first eligible may do so during the next
 1018 occurring annual enrollment period or with satisfactory proof of loss of other coverage.

1019 (7) Premium payment for Commission coverage must be made one month in advance of
 1020 coverage in order for coverage to become effective.

1021 (8) As a condition of employment, employees shall provide information to the Commonwealth as
 1022 required by law, including but not limited to disclosures required by the Health Care Reform
 1023 Act.

1024 | (9) If an ~~employee's~~employee is requesting a coverage effective date ~~changes~~change to a
 1025 different month, the employee's effective date of coverage shall be determined by the
 1026 Commission, and is subject to receipt of premium before coverage becomes effective.

(10) Recalled Employees who do not continue their coverage with the Commission during the period when they are laid off shall be treated as ~~new employees~~re-employed persons, consistent with § 9.19.

§ 9.02: Elected Officials

(1) Officials elected by popular vote are eligible for coverage on the first day of the month nearest the date that they begin their term of office~~-, excepted as noted in clause (2).~~ Appointed employees and officials are subject to the waiting period for coverage in 805 CMR 9.01(3).

(2) Elected officials who are Municipal Employees and who have a Regular Work Week of less than 18.75 hours are eligible for coverage only at local option, per G.L. c. 32B, § 2 (d), "Employee." Municipal Employers shall inform the Commission by May 1 of each year of any change in eligibility of elected officials. Notification of the local option is binding on the Municipal Employer for the fiscal year starting that July 1.

§ 9.03: Eligibility for Health Coverage

(1) ~~Surviving Dependents or Spouses, Municipal Insureds, Survivors, and Elderly Governmental Retirees, and Municipal Insureds who join Commission coverage pursuant to M.G.L. c. 32B, § 49~~ are eligible ~~only for to enroll in~~ Health Coverage~~-, without electing any other benefit.~~ All other Employees and Retirees~~-, including Retired Municipal Teachers~~ must be enrolled in Basic Life Insurance in order to be eligible for Health Coverage.

(2) Persons who cancel their Medicare coverage will next be eligible for the Commission's Health Coverage on July 1st after they reapply for Medicare and are reinstated to Medicare coverage. Commonwealth Retirees shall be solely responsible for any Medicare penalties incurred by the cancellation.

(3) During any of the Commission's annual enrollment periods, uninsured ~~employees, retirees~~Employees, Retirees and ~~survivors~~Survivors may elect Commission health coverage, which shall become effective the next occurring July 1st.

(4) Employees, ~~Municipal Insureds~~, Retirees, Survivors, and ~~survivors~~Dependents may enroll in Commission health coverage if they provide acceptable proof of loss of other coverage and are otherwise eligible for the coverage. The Commission shall determine the effective date of coverage.

(5) Employees, Retirees, and Survivors who terminate coverage due to non-payment of premiums may re-apply during any of the Commission's Annual Enrollment periods provided they are otherwise eligible for coverage.

§ 9.04: Individual and Family Health Coverage

(1) Employees ~~and Municipal Insureds~~ who elect Individual Health Coverage at the time of hire may later elect Family Health Coverage due to a change in family status (e.g., marriage or adoption, spouse's loss of other coverage), subject to verifying documentation acceptable to the Commission, including, but not limited to, marriage and birth certificates. Verification that requires translation shall be at the applicant's expense. The effective date of the family status change is determined by the Commission. ~~Insureds who elect Family Health Coverage for births and marriages that occur on or after the 16th day of a month will not be charged premium for that month; insureds who elect family coverage for those events that occur on or before the 15th day of a month must pay the full premium cost for the month.~~

(2) Employees, Retirees, and ~~Municipal Insureds~~ Surviving Spouses whose dependents cease to be eligible for Commission coverage must notify the Commission within 30 days of such occurrence. The Commission shall determine the effective date of dependents' coverage termination.

(3) Employees, ~~and Municipal Insureds~~, Retirees or Surviving Spouses may change their Family Coverage to Individual Coverage only by providing proof of their Dependents' other coverage or a change in family circumstance as described in 805 CMR 9.04. The Commission's decisions relating to coverage termination requests are final and binding.

(4) If a ~~Dependent's~~ death changes a ~~surviving Dependent's~~ State Employee, State Retiree, or State Survivor's coverage status from Family to Individual coverage, the Commission ~~shall~~ may refund up to two years of premium overpayment, if any, after the ~~Dependent's~~ death is reported to the Commission.

~~(5) Non-medicare family members must enroll in the same Health Coverage plan.~~

(5) Where a Retiree or Surviving Spouse is enrolled in a Commission Medicare plan, any non-Medicare-eligible Dependent may enroll only in Health Coverage with the same carrier as the Retiree or Surviving Spouse, and all such Dependents must enroll in the same plan. Likewise, where a Retiree or Surviving Spouse is enrolled in a non-Medicare plan, any Medicare-eligible Dependent may enroll only in a Commission Medicare plan with the same carrier as the Retiree or Surviving Spouse, and all such Medicare-eligible Dependents must enroll in the same Medicare plan. Any Medicare-eligible Dependent of a Retiree or Survivor in a Commission Medicare plan must enroll in the same Commission Medicare plan as the Retiree or Survivor.

(6) Divorced spouses of Employees, ~~or Retirees~~ ~~or Municipal Insureds~~ cannot be terminated from Commission health coverage for reasons of additional cost when their children are no longer enrolled in the coverage unless the divorced Employee, ~~or Retiree~~ ~~or Municipal Insured~~ has remarried or the divorce agreement expressly defines such a scenario as constituting additional cost.

(7) For an Employee, Retiree, or Surviving Spouse with Family Health Coverage to enroll in a plan with a defined geographical enrollment area, all enrolled family members, including all covered Dependents, must reside in the plan's service area. For the purposes of this clause, Children younger than 19 years of age and Students are deemed to reside with the Employee, Retiree, or Surviving Spouse on whose plan they are Dependents, unless that Employee, Retiree, or Surviving Spouse is not the Child's or Student's custodial parent. In that case, Children younger than 19 years of age and Students are deemed to reside with their custodial parent. In the event that an enrolled family member no longer resides in the plan's service area, the Employee, Retiree, or Surviving Spouse must either:

a) disenroll the Dependent who no longer resides in the plan's service area, subject to other applicable requirements as outlined in this section; or

b) enroll in a plan with an appropriate service area, or with no geographical restrictions.

If the latter course is elected, the Employee, Retiree, or Surviving Spouse must change plans concurrently with the change in residence, outside of the Annual Enrollment period if necessary.

§ 9.05: Duplicate Coverage Prohibited

~~¶~~(1) In the event that a person is eligible for Commission benefits as an Employee or Retiree of more than one Employer, or as more than one of the following categories: Employee, Retiree, and Dependent; the person must elect a single such status for the purposes of enrolling in Commission benefits. For example, a person who qualifies both as a State Retiree and as a Municipal Employee may elect to be treated as either one, but not both.

(2) If both members of a married couple are Employees or Retirees and both are enrolled in Commission coverage, they may either:

(a) each have Individual Health Coverage; or

(b) have Family Health Coverage covering both spouses and all other eligible Dependents.

If a couple elects Family Health Coverage, only one spouse of the couple may be the named Insured for the Family Coverage. Both Employee spouses may each enroll in Basic Life Insurance coverage.

(3) If both members of a divorced couple are Employees or Retirees and both are enrolled in Commission coverage, they may have Family Health Coverage covering both former spouses and all other eligible Dependents. Alternatively, each may independently elect Individual or Family Health Coverage. In that case, a Dependent may not be covered on more than one plan.

§ 9.06: Leaves of Absence

(1) Employees may continue their Commission coverage while on an authorized leave of absence without pay for reasons other than personal illness or injury. Such Employees are responsible for the entire premium cost; no Employer contribution shall be made, except as otherwise provided in 805 CMR 9.06.

(2) Employees on leave of absence without pay for six or more continuous months will only be eligible for coverage if the Commission approves. Such Employees must pay the entire premium and must apply to renew their application with the Commission every six months.

(3) Employees who are absent from work due to personal illness or injury, for which they are receiving Worker's Compensation benefits pursuant to ~~M.~~G.L. c. 152 or any similar law or regulation, and whose salary ceases due to lack of sick leave credits, must be given written notice from the Employer and an accompanying application that they may be eligible to continue their coverage by paying the employee's share of the premium cost. The Commission shall make a determination as to applicants' eligibility when it receives their completed applications. Employees approved for coverage shall recertify their continued eligibility for coverage with the Commission at six month intervals.

(4) Employees who are not entitled to receive salary or wages while awaiting a determination of eligibility for Worker's Compensation benefits shall be deemed to have been granted a leave of absence without pay, and may continue their existing coverage by paying the entire monthly premium cost with no contribution made by the Employer. Employees approved for Worker's Compensation may apply for a reduction of premium, which the Commission will review and may refund the amount for which the employer is properly responsible.

(5) Entitlement to Worker's Compensation benefits does not entitle a terminated Employee to continue Commission life or health coverage.

(6) Employees on a leave of absence for one year who pay the Employee's share of premium may thereafter continue to receive their Health Coverage if they continue to pay the Employee's share of the premium cost and the Employee's agency pays the Commonwealth's share of the premium cost.

(7) Employees on a medical leave of absence (excluding worker's compensation, industrial accident or maternity leave) may continue to receive their Health Coverage by paying the

Employees' share of the premium cost only after they have exhausted their accrued sick and vacation time.

(8) Employed and Re-employed Members of the Uniformed Services are subject to the requirements of the Uniformed Services Employment and Re-employment Rights Act (USERRA).

(a) Employed and re-employed members of the uniformed services who are absent from employment by reason of service may elect to continue their Commission coverage up to the lesser of either 24 months from the date their absence begins or the day after the date on which they fail to apply for or return to their employment positions. Members who elect to continue their Commission coverage are required to pay the full premium cost; however, members who perform service for fewer than 31 days are not required to pay more than the Employee's share, if any, for such coverage.

(b) Members who do not elect to continue Commission coverage or do not pay for it in a timely manner may, upon the members' departure for service, have their coverage terminated unless their failure to elect was excused because continued payment was impossible, unreasonable or precluded by military necessity. The Commission shall reinstate such members' health coverage retroactively if they elect to continue coverage and pay all unpaid amounts due.

(c) Re-employed members, except in the case of those who elect continuing coverage, will not have a waiting period if such a waiting period would not have been imposed for reasons other than uniformed service.

(9) Employees who are absent from work for 30 days or more are considered to be on leave of absence for the purpose of Commission coverage.

§ 9.07: Subsequent Determination of Ineligibility

If premiums have been paid and accepted on behalf of a person enrolled in Commission coverage and the Commission later determines that the person was not eligible, Commission coverage shall cease ~~on~~ as of the date that end of the period for which the Commission last received premium payment. The ineligible person shall not be entitled to continuation coverage except as required by federal law.

If an employee initially is eligible and insured under the Commission's programs but thereafter becomes ineligible due to a change in employment or status in the service of the Commonwealth or of one of its participating municipalities, his or her Commission coverage shall terminate at the end of the month following the month in which the change that caused the Employee's ineligibility occurs - or a later date as determined by the Commission. Such employees ~~may~~ shall

be entitled to Continuation Coverage, unless the ineligibility is due to termination for gross misconduct.

§ 9.08: Employees ~~and Municipal Insureds~~ not Entitled to Receive a Pension or Retirement Allowance

Except for Elected Officials, Employees ~~and Municipal Insureds~~ who are not entitled to receive a pension or a retirement allowance when they terminate employment or who subsequently lose or withdraw their pension after retirement are not eligible to continue Commission Coverage. However, Employees other than Municipal Employees may be entitled to Commission life insurance portability or conversion and health insurance Continuation Coverage as set forth in 805-CMR §§ 9.0813 and 9.14; Municipal ~~Insureds~~ Employees and their Dependents may be eligible for health insurance Continuation Coverage as set forth in 805-CMR §§ 9.0813 and 9.14.

§ 9.09: Surviving Spouses

Surviving Spouses may elect to remain insured only for Health coverage until their remarriage or death. They must apply for Surviving Spouse coverage within six months of the Employee's or Retiree's death. Additional time to apply may be granted for delays due to the applicant's medical condition or the existence of other coverage that has since terminated.

(1) Surviving Spouses of deceased Employees or Retirees who were enrolled in Commission Coverage at the time of the Insureds' death may elect only Health Coverage until their remarriage or death. Surviving Spouses must apply for Surviving Spouse Health Coverage.

(2) Surviving Spouses who are eligible for coverage as Employees ~~are not eligible for survivor coverage unless they terminate employment.~~ Enrollees who are eligible for coverage as Retirees are not eligible for survivor coverage ~~unless they terminate employment.~~

(3) Divorced or legally Separated Spouses are not Surviving Spouses and are not eligible for Surviving Spouse coverage.

(4) Surviving Spouses who receive a retirement allowance must have their Health Coverage premium deducted from their retirement allowance.

(5) Widows and widowers of deceased Insureds are only eligible for Surviving Spouse coverage if the deceased was enrolled in Commission coverage at the time of death.

§ 9.10: Surviving Dependents

Surviving Dependents ~~of insured Employees, insured Retirees, Municipal Insureds or insured Surviving Spouses~~ may elect ~~to continue their~~ Health Coverage until the Surviving Dependent ~~enrolls~~becomes eligible to enroll in other group health coverage or ~~turns 19~~becomes 26 years ~~old of age~~, whichever ~~first~~ occurs first. Surviving Dependents must apply for Health Coverage within six months of the employee's or Retiree's death. For good cause shown, the Commission may grant additional time to apply.

§ 9.13: Conversion of Health Coverage: Continuation Coverage Options

(1) Insured Employees ~~and Municipal Insureds~~ in good premium standing who terminate their employment and whose Dependents become ineligible for Commission Health Coverage may convert their Health Coverage to non-group conversion or continuation Health Coverage, including Federal "COBRA" coverage, and Massachusetts Health Connector Authority coverage, provided that they apply for health coverage 31 days following the later of:

(a) termination of Family Health Coverage; or

(b) the date that the former health plan or the Commission notifies the former Employee of his or her right to obtain non-group coverage, provided that the Employee is in good premium payment standing on the date of his or her group Health Coverage termination.

(2) Surviving Spouses or Surviving Dependents who are no longer eligible for Health Coverage and who decline Health Coverage as survivors may enroll in a non-group plan of health coverage, provided that they make timely application to the health plan. The effective date of non-group health coverage shall be determined by the health plan.

(3) Insured Employees, Retirees, or Surviving Spouses or Dependents who remain eligible for Commission coverage but who voluntarily withdraw from or decline to enroll in Commission coverage, or are terminated for nonpayment of premium, are not eligible for non-group conversion coverage.

§ 9.14: Conversion of Life Insurance: Continuation Coverage Options

Insured Employees who leave employment or become ineligible for Commission coverage due to a reduction in hours may either apply for portable group term life insurance similar to their Commission life insurance or may convert their life insurance to a non-group life insurance plan with the carrier providing Commission life insurance coverage when the Commission coverage ends without having to provide medical evidence of insurability. Employees must apply to the group life insurance carrier for portable life insurance coverage within 31 days of terminating Commission coverage and pay the first month's premium within 31 days of the date of the

carrier's premium bill or within 15 days of the date the notice of conversion right is sent to the employee. Employees applying for non-group conversion coverage must do so within 90 days of the Commission's coverage termination. Only applicants in good premium standing when terminating their employment can be considered for continued coverage.

§ 9.15: Misstatement of Information and Misuse of Benefit Plans

(1) An Insured's coverage may be terminated, in addition to other civil or criminal penalties, if the Commission determines that the Insured provided incorrect information in submitting a medical evidence of insurability or other such form that resulted in approval of the Insured's coverage request. The Commission shall establish the extent and duration of the termination.

(2) Any Insured who procures services fraudulently or submits false claims for himself or herself, or otherwise enables a person who is not eligible for Commission coverage to fraudulently enroll, procure services for, or submit claims for Commission coverage shall, upon determination by the Commission and in addition to other civil or criminal penalties that may be imposed, forfeit his or her eligibility for Commission coverage. The Commission shall establish the extent and duration of the forfeiture.

(3) Personal reimbursement of out-of-country health care claims will only be provided to Insureds who produce all related records requested by the plan and, as necessary, their translation; an itemized bill for health care claimed and, as necessary, its translation; and satisfactory proof of personal payment of the claims by cancelled check or credit card statement. Reimbursement is subject to the reasonable and customary payment as determined by the health plan, based on the locality where services were rendered.

§ 9.16: Retired National Guard Technicians

(1) National Guard Technicians retired after January 1, 1969 who receive a pension from the State Retirement System may become insured as Retirees, notwithstanding the period of time from January 1, 1969 to their retirement when they were Federal employees, provided that they were insured on the date of transfer from the state employment to federal employment.

(a) Such National Guard Technicians must complete an application for Commission coverage.

(b) The application for coverage must be received by the Commission within 31 days following the date of retirement. Persons who fail to submit a timely application may reapply at the Commission's next occurring annual enrollment.

(2) National Guard Technicians retired after January 1, 1969 who receive a pension from the State Retirement System but who have never been insured through the Commission may be

1295 insured as Retirees only after compliance with the retirement pre-conditions described in 805
1296 CMR 9.16.

1297 (3) National Guard Technicians who have no right to receive a pension from the State
1298 Retirement System are not eligible to be insured as Retirees.

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1300 **§ 9.17: Surviving Spouses of National Guard Technicians**

1301 (1) Surviving spouses of insured Retired National Guard Technicians may be insured for health
1302 insurance only.

1303 | (2) Surviving spouses of Retired National Guard Technicians who were federal employees at the
1304 time of death may be insured for health insurance only, provided that such National Guard
1305 Technicians were insured by the Commission on the date of their transfer from state employment
1306 to federal employment.

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1308 **§ 9.18: Retired Employees' Return to Active Employment**

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1310 Retirees who subsequently are hired for a position with benefits by the Commonwealth or a
1311 Municipal Employer may either continue their Commission coverage as active employees if they
1312 waive their monthly retirement allowance, or may continue to have their retiree premium
1313 deducted from their retirement allowance.

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1315 **§ 9.19: Re-employed Persons in State positions**

1316 (1) Insured State Employees ~~or Municipal Insureds~~ who terminate employment while in good
1317 premium payment standing, who are re-hired as State Employees in a position with benefits and
1318 begin employment before Commission coverage ends under their prior public employment, shall
1319 continue to be insured without a break in existing coverage, provided that they submit a timely
1320 application for Commission coverage.

1321 (2) Insured State Employees ~~or Municipal Insureds~~ who terminate employment while in good
1322 premium payment standing and are re-hired ~~to their prior state position~~ as State Employees after
1323 their Commission coverage ends shall be insured as new Employees and will be subject to the
1324 New Employee waiting period for Commission coverage.

1325 (3) Notwithstanding clause (2) of this section, Insured State Employees who terminate
1326 employment while in good premium payment standing and are re-hired as State Employees in a

position with benefits within two years of the date of termination of their employment shall be considered to have been hired on their original hire date for the purposes of computing the Commonwealth's share of their premiums.

(4) Insured State Employees who are reinstated in their prior position as the outcome of labor arbitrations shall be considered to have been hired on their original hire date for the purposes of computing the Commonwealth's share of their premiums. Their benefits as active State Employees will be reinstated prospectively.

§ 9.20: Retirement - General

(1) Retirees entitled to a pension or retirement allowance may continue Basic Life and Health Insurance coverage, and Additional Life Insurance by applying to continue the coverage and continue paying the required premium. ~~Commonwealth~~State Retirees, Retired Municipal Teachers, and eligible Municipal Retirees may also enroll in the Commission's retiree dental coverage by submitting an enrollment application in a timeframe as determined by the Commission.

(2) ~~Commonwealth~~State Retirees who never have been insured through the Commission and initially apply for Commission coverage as State Retirees are eligible to apply for the Commission's Retiree Basic Life, Health Coverage and Retiree Dental coverage.

(3) Retirees who are re-hired as employees under the applicable provisions of ~~M.~~G.L. c. 32 and are receiving adjusted salary or wages are not eligible to be insured as active employees. Retirees who waive and renounce their rights to all pension or retirement allowance payable to them for a period of time in accordance with ~~M.~~G.L. c. 32, and are not rehired as full-time employees for a period of time that does not constitute Emergency Employment, may be insured as Employees ~~or Municipal Insureds~~ subject to payment of the Employee's ~~or Municipal Insured's~~ share of the premium.

~~(4) Commonwealth or Municipal Insureds~~(4) Eligible Retirees who voluntarily withdraw from Basic Life or Basic Life and Health Coverage may apply to re-enroll in Commission coverage either during the next annual enrollment or if they provide acceptable proof of loss of other coverage.

(5) Deferred retirees are considered to be employees on leaves of absence without pay for as long as they retain the right to receive a retirement allowance from a participating retirement system and do not withdraw their pension monies from the retirement system. Persons receiving a retirement allowance cease to be Deferred Retirees.

(6) Once a Retiree enrolls in a health plan, the next opportunity to change plans is the GIC's next Annual Enrollment period, except as otherwise required by law.

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1363 | **§ 9.21: Additional Life Insurance**

1364 (1) All eligible Employees enrolled in Basic Life Insurance may apply for Additional Life
1365 Insurance consisting of group term life insurance and accidental death and dismemberment
1366 insurance. New Employees who enroll when first eligible are eligible for Additional Life
1367 Insurance in an amount up to eight times their salary without providing medical evidence of
1368 insurability.

1369 (2) Evidence of insurability shall be required when an Employee:

1370 (a) applies for initial coverage after the deadline for applying has passed, unless certain life
1371 events occur that qualify under the policy for coverage without providing such evidence; or

1372 (b) seeks to increase the amount of his or her Additional Life Insurance; or

1373 (c) seeks to be reinstated after losing coverage for failing to pay the required premium.

1374 (3) If a physical examination is required to determine eligibility for Additional Life Insurance,
1375 the life insurance carrier shall review the medical evidence and determine eligibility for the
1376 additional coverage based upon its underwriting standards. Such standards shall be consistent
1377 with the life insurance underwriting standards in general use by the insurance industry. In
1378 addition, the life insurance carrier's underwriting criteria shall not consider the applicant's age,
1379 gender, occupation or amount of life insurance requested. Consideration shall be given only to
1380 the applicant's medical evidence of insurability, recognizing the size of the group and volume of
1381 insurance administered by the Commission in determining standards of acceptability and
1382 insurance risk.

1383 (4) Upon retirement, Retirees may continue or reduce the amount of their Additional Life
1384 Insurance in effect at that time, upon full and timely premium payment. Retirees who cancel or
1385 reduce their Additional Life Insurance are eligible to continue their coverage directly with the
1386 carrier. Persons who have not previously had Additional Life Insurance are not eligible for the
1387 coverage upon or after retirement.

1388 (5) Pensioned justices who are recalled to judicial duties on full-time assignment are eligible for
1389 Additional Life insurance without providing medical evidence of insurability if they waive their
1390 pension for the duration of the full time recall period.

1391 (6) The effective date of an Employee's life insurance beneficiary designation is the date that the
1392 Commission receives the completed beneficiary designation form.

1393 (7) Employees who are enrolled in Basic Life Insurance but do not enroll in Additional
1394 (Optional) Life Insurance when first hired may later elect the coverage due to a change in family
1395 status without having to provide proof of good health. Applicants must apply for the Additional

1396 Life Insurance and provide evidence of the family status change within 31 days of the event
1397 causing the status change.

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1399 | **§ 9.22: Dental and Vision Benefits**

1400 The Commission and the vendor(s) providing Dental and Vision benefits shall determine the
1401 conditions for participation, the amount of benefits and their duration, premium rates and all
1402 effective dates of coverage.

1403 ~~For employees~~Certain State Employees who are not covered by collective bargaining ~~and do not~~
1404 ~~have other non-preventive dental care coverage, certain preventive care, materials and services~~
1405 are eligible for Dental and Vision benefits that are offered primarily to managers, legislators,
1406 legislative staff, and certain Executive Office staff. All Employees of ~~authorities~~, higher
1407 education, ~~and the Trial Court system, and authorities other than the Massachusetts Bay~~
1408 Transportation Authority are ineligible for Commission Dental and Vision coverage. Certain
1409 Massachusetts Bay Transportation Authority employees who are not covered by collective
1410 bargaining are eligible for Commission Dental and Vision coverage. ~~Persons enrolled in the~~
1411 ~~Preferred Provider Organization dental plan whose dentist ceases to be a plan dentist, as are~~
1412 certain confidential Employees. Employees may only change plans ~~only~~ during Annual
1413 Enrollment, even if their dentist leaves the next occurring annual enrollment plan.

1414

1415 | **§ 9.23: Pre-tax Options for Commission Benefits**

1416 Employees' share of basic life and health insurance premiums may be deducted from their
1417 paychecks on a pre-tax basis, and may change the tax status of their premium deductions during
1418 annual enrollment or upon a qualifying event.

1419 | (1) Health Care Spending Account Program. Active ~~employees~~State Employees who work at
1420 least 18.75 hours in a 37.5 hour work week or 20 hours in a 40-hour work week and are eligible
1421 for Health Coverage may arrange to pay for their out-of-pocket health care expenses on a pre-tax
1422 basis through the Commission's Health Care Spending Account program. State Employees pay a
1423 specified sum determined by the Commission by payroll deduction for non-covered health-
1424 related expenses. The Commission and the vendor(s) administering pre-tax options for
1425 Commission Employees establish the procedures, terms and conditions consistent with Internal
1426 Revenue Code rules. Such rules require that any unused funds in a participant's account at the
1427 plan's year end be forfeited.

1428 | (2) Dependent Care Assistance Program. Active State Employees who have employment-related
1429 dependent care expenses for Dependent children who are younger than 13 years old or are
1430 younger disabled adult dependents may pay for certain dependent care expenses through the

Commission's Dependent Care Assistance Program. Participants elect an annual dollar amount per family to be taken as a payroll deduction, up to a maximum set by the Commission, to pay for qualified child and elder day care, after school programs, and day camp dependent care expenses.

§ 9.25: Appeals

(1) Any person who is aggrieved by a decision of the Commission, or by a final decision of one of the Commission's self-insured plan administrators about benefits may appeal in writing to the Commission's Executive Director. Benefits that are explicitly excluded from coverage in the plan of benefits are not appealable. The Executive Director shall consult with the Commission's General Counsel to determine whether the matter warrants presentment to the Commission's Appeals Committee. If presentment is warranted, the Executive Director shall enter the matter on the Commission's Appeals Docket for resolution via the Commission's appeals procedures. The Appeals Committee's decisions are final and binding, and may only be re-considered if new information that was unknowable at the time of the initial appeal to the Appeals Committee would alter the outcome of the appeal. Appellants may pend their appeals to the Commission up to a maximum of 120 days after their initial filing in order to obtain additional information. Appeals that exceed the 120 day period will be closed without prejudice to the appellant.

(2) Notwithstanding clause (1), the Executive Director may modify appeals procedures in order to achieve compliance with requirements of federal law, including but not limited to 42 U.S.C. § 300gg-19. To that end, Commission's Executive Director may delegate external appeals procedures to the Commission's self-insured plan administrators. If the Executive Director has delegated appeals procedures to one or more plan administrators, any person who is aggrieved by a decision of the Commission, or by a final decision of one of the Commission's self-insured plan administrators about benefits, may appeal in writing to the plan administrator.

(3) Notwithstanding clauses (1) and (2), eligibility decisions by the Commission are final and not subject to appeal procedures under this section.

§ 9.26: Health Insurance Buy-out Option

Insured State Employees and Insured State Retirees may buy out their Commission health coverage during annual enrollment or at a time designated by the Commission in the fall if they have other non-state health insurance coverage that is comparable to Commission health coverage and is verified by documentation acceptable to the Commission- and must maintain Basic Life Insurance. Eligible Employees and Retirees receive 25% of the full-cost monthly premium in lieu of health insurance benefits for a maximum of one 12-month period, ~~and~~

1466 | payment starting either July 1 or January 1. Full cost monthly premium is equal to determined
1467 | based on the Employee's last Commission health plan and coverage type (individual vs.
1468 | family), and is subject to applicable taxes.

1469

1470 | **§ 9.27: Long-term Disability Insurance**

1471 | All active full-time and half-time State Employees who work at least 18.75 hours in a 37.5-hour
1472 | work week or 20 hours in a 40-hour work week are eligible for Long-term Disability benefits.
1473 | Active State Employees who are eligible for Basic Life Insurance coverage are eligible for the
1474 | Commission's Long-term disability insurance program sponsored by the Commission. The
1475 | conditions for participation, the amount of benefits and their duration, and the premium rates
1476 | shall be jointly determined by the Commission and the Long-term Disability insurance carrier
1477 | providing the Long-term Disability Insurance plan.

1478 | New ~~employees~~State Employees may enroll in the Long-term Disability program within 31 days
1479 | of hire without providing acceptable evidence of good health and thereafter may enroll in the
1480 | program at any time by providing acceptable proof of good health to the Long-term Disability
1481 | carrier.